Staple

COUNTY OF LOS ANGELES

LOS ANGELES COUNTY + USC MEDICAL CENTER

DEPARTMENT OF HEALTH SERVICES

Last Name | First | Date of Birth (Mo/D/Yr) | Medical Record #

Address | City | State | Zip Code | ( ) Phone #

HEREBY AUTHORIZES:

☐ DEPARTMENT OF HEALTH SERVICES

☐ Other: _____

Facility Name | Street Address | City, State | Zip Code

To Release Protected Health information To:

Department of Health Services (DHS) Housing for Health Program.

TYPE OF RECORDS TO BE DISCLOSED

☐ Ambulatory Clinic Records	☐ Lab & Pathology Reports	☐ Emergency Department Records
☐ Progress Notes	☐ Discharge Summary	☐ Insurance Information
☐ History & Physical	☐ Operative Reports	☐ Imaging Reports
☐ HIV/AIDS Test Results		
☐ Other, specify:		

Housing for Health will obtain up to five (5) years of medical information unless otherwise specified:

_____ (Date/Timeframe)

The following information will only be released if you give your specific permission by providing your initials to the following:

_____ I agree to the release of information pertaining to mental health diagnosis or treatment that are otherwise protected under Welfare & Inst. Code 5328, excluding psychotherapy notes defined by 45 CFR 164.501

IMPRINT I.D. CARD (NAME MRUN CLINIC/WARD)

T-LAC101422

FILE IN MEDICAL RECORD

THE PURPOSE OF THE DISCLOSURE IS: To permit Housing for Health and their contractors 1) to determine eligibility for Housing for Health resources; 2) to provide the minimum necessary protected health information to community based organizations, who are contracted with DHS to arrange for housing, case management and integrated and coordinated services; 3) to assist me in the application and receipt of any public benefit which I may be otherwise entitled to; and 4) to provide me with on-going case management services.

NOTICE

Department of Health Services and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your PHI confidential. If you have authorized the disclosure of your PHI to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentially laws.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

- I understand this authorization is voluntary and will not affect my ability to obtain treatment. However, without a signed Authorization, DHS Housing for Health may not have adequate information to determine my eligibility for housing services.
- I am entitled to receive a copy of this Authorization.
- I may revoke this authorization at any time, provided that I do so in writing and may use the form below.
- The revocation will take effect when DHS receives it, except to the extent that DHS or others have already relied on it.

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this Authorization expires five (5) years from the date of signing below.

AUTHORIZATION

I have had the opportunity to review this and understand what it says. By signing, I agree that it accurately reflects my wishes and I affirm that I have not place any restriction on the release of any information authorized for release by this Authorization.

_____ _____

Signature of Patient/Legal Representative Print Name

Date: _____/_____/_____

If signed by other than patient, state relationship and authority to do so:

_____

Witness: _____

Print Name: _____

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Right to Revoke This Authorization – I understand that I may revoke this Authorization for Housing for Health at any time by giving written notice of my revocation to the DHS facility at the address listed below. I may use the Revocation of Authorization at the bottom of this form. Mail or deliver the revocation to the following address:

I also understand that a revocation will not affect the sharing of information done in reliance of this Authorization prior to it's being revoked.

REVOCATION OF AUTHORIZATION

Signature of Patient/Legal Representative: _____

If signed by other than patient, state relationship and authority to do so:

_____

DATE: _____/_____/_____

IMPRINT I.D. CARD (NAME MRUN CLINIC/WARD)